

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11332  
131a  
g2

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

Cecil County

Elkton City or town

(If outside city or town limits, write RURAL and give nearest town)

15 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Rev. Dr. James Warren

Albinson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Virginia C. Albinson

7. Birth date of deceased (mo., day, yr.)

November 10, 1896

6. (c) If alive, give age 37 years

8. AGE:

Years

Months

Days

11 less than one day

52

15

hrs.

min.

9. Birthplace Bloomfield, New Jersey

(Town, county, and state)

10. Usual occupation

Clergyman

11. Industry or business

Episcopal

12. Name

Thomas Albinson

MOTHER FATHER

13. Birthplace

England

MOTHER

14. Maiden name

Margaret Murphy

15. Birthplace

Pennsylvania

16. Informant

Virginia C. Albinson

Address

Elkton, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 27, 1948

(month) (day) (year)

Cemetery or crematory St. Mark's Cemetery

Location Aikin, Maryland

18. Funeral director

Reva Catherwood

Address

Perryville, Md.

19. Nov. 27

1948

F. R. Fraser

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war World War I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 November

1948 at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

24 November 1948 to 25 November 1948

and that I last saw h. l. m. alive on 25 November 1948

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertension

DURATION

12 hrs

Due to Arteriosclerosis

8 yrs

Other conditions Cardiac Arrest Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE George D. Kress, Jr.

M. D. or other

Address Elkton, Md. Date signed 25 Nov 48

RECEIVED

NOV 29 1946

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11333

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Civil  
 County: Eckerton  
 City or town: Eckerton (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 68 days  
 Hospital, Institution, or street address where death occurred: Union Hospital  
 How long in hospital or institution? 68 days

## 3. (a) FULL NAME

Harry Herbert Austin

## 3. (b) Social Security Number

(Austin)

4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Mrs

6. (b) Name of husband or wife: Ethel M. Austin

7. Birth date of deceased (mo., day, yr.): Sept 29 - 1890 6. (c) If alive, give age: years

8. AGE: 58 Years 1 Months 16 Days If less than one day: hrs. min.

9. Birthplace: New Castle Co. Delaware (Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business:

12. Name: Henry Austin  
MCOTHER FATHER: New Castle Co Del.

13. Birthplace: New Castle Co Del.

14. Maiden name: Mary Jane Isaac

15. Birthplace: Sussex Co. Del.

16. Informant: Hospital Nurse

Address: Union Hosp. Eckerton Md

17. Burial: Burial Date thereof: 11/19/48 (month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery or crematory: Bethel Cemetery

Location: near Chesapeake City Md

18. Funeral director: G. Ruth Daniels

Address: Middletown Del.

19. Nov 17 1948 (Date rec'd by registrar) F. B. Fraser (Signature) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil  
 City or town: Earleville (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: Stack's Point (If rural, give LOCATION)

2.(a) If veteran, name war:

## MEDICAL CERTIFICATION

2d. DATE OF DEATH: Nov. 15 1948 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1948 to Nov 15 1948 and that I last saw him alive on Nov. 15 1948

Immediate cause of death:

Right hemiplegia DURATION: Sept 7 1948

Due to: Hypertension CVD 2 years

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

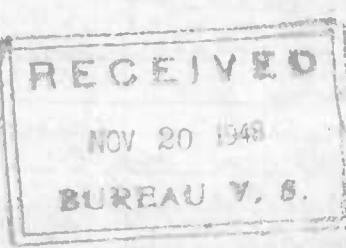
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. H. Davis M.D. M. D. or other: Chesapeake City Md

Date signed: 11/15/48



Me

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11334

Reg. Dist. No. 91

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Cecil

City or town

Chesapeake City R.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lillian Broadwater Bailey

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Charles H Bailey

## 6. (c) If alive, give age years

## 7. Birth date of deceased (mo. day. yr.)

mch 15 1905

## 8. AGE:

43

8

15

.

hrs.

min.

## 9. Birthplace

Town Point Cecil Md

(Town, county, and state)

## 10. Usual occupation

House wife

## 11. Industry or business

Willing Broadwater

## 12. Name

Phila Pa

## 13. Birthplace

Alice Smith

## 14. Maiden name

Phila Pa

## 15. Birthplace

Charles H Bailey

## 16. Informant

Chesapeake City Md

## Address

Burial Date thereof Dec 2 1948

## (Burial, cremation, or removal. Which?)

(month)

(day)

(year)

## Cemetery or crematory

Johnstown Methodist Cemetery

## Location

Cecilton Md R.D

## 18. Funeral director

J W C Pippin

## Address

Eckton Md

## 19. at Date rec'd by registrar

Dec 1 at 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Cecil  
Chesapeake City R.D.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

November 30 1948 at 4a

April 10 1948 to Nov 30 1948

and that I last saw her alive on Nov 30 1948

## Immediate cause of death

Anoxemia of lungs

Due to Sclerification of lungs

Due to Case under poor

Other conditions Fracture of skull

or Circumference of lungs

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

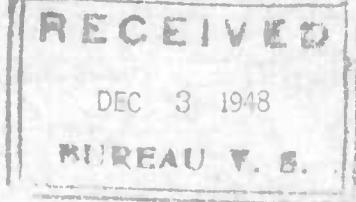
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

H. D. Dorsey MD M. D. or other

Address Chesapeake City Md Date signed 12/1/48



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11335  
94a  
95

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

Cecil

City or town

Conowingo, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 hours.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ernest McGuffin

Brammer

## 3. (b) Social Security Number

229-12-1817

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Mary Brammer

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

Oct. 12, 1893

8. AGE:

Years

Months

Days

If less than one day

55

29

hrs.

min.

9. Birthplace

Simmonstown, West Va.

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

Benjamin H. Brammer

FATHER

12. Name

Va.

13. Birthplace

MOTHER

Nancy Eperly

14. Maiden name

Va.

15. Birthplace

16. Informant

Mary Brammer

Address

Rising Sun Md.

17. Burial

Date thereof Nov 14, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

West Nottingham

Location

Colusa Md.

18. Funeral director

J. E. Tysor

Address

Rising Sun Md.

19. Date rec'd by registrar

Nov 13 1948

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Cecil

City or town

Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

November 11 1948 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

to 19...

and that I last saw h... alive on

19...

Immediate cause of death

acute

coronary

disease

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

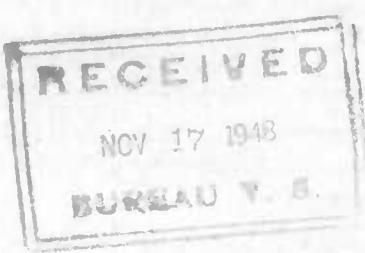
Medical Examiner

for Cecil County

M. D. or other

Address

Date Sig'd



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11336

164a

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

## 1. PLACE OF DEATH:

County

Cecil  
Rising Sun, Rural

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

68 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Howard n. Brickley

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Male

white

Widowed

## 6. (b) Name of husband or wife

Mary Brickley

6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

April 11 1879

## 8. AGE:

Years  
69Month  
7Day  
5

If less than one day

hrs.

min.

## 9. Birthplace

Rising Sun, Md.

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

## MOTHER FATHER

## 12. Name

William A. Brickley

## 13. Birthplace

Rising Sun, Md.

## 14. Maiden name

Rachel Maxwell

## 15. Birthplace

Rising Sun, Md.

## 16. Informant

Mrs Rufus Jackson

## Address

Rising Sun, Md. R. R. O.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Nov. 19 1948  
(month) (day) (year)

## Cemetery or crematory

Ebenezer

## Location

Outside Rising Sun

## 18. Funeral director

J. E. Jason

## Address

Rising Sun, Md.

## 19. Date rec'd by registrar

Nov. 17 1948

(Date rec'd by registrar)

J. Washington

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Cecil

City or town

Rising Sun

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

November 16 1948 at 11a.m.

## 20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. . . . .

19. . . . .

and that I last saw him alive on

19. . . . .

## Immediate cause of death

Strangulation  
& hanging

Due to

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Suicide Date of . . . . .

Where did injury occur Rising Sun, Cecil Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Home Date of . . . . .

Meane of injury Rope

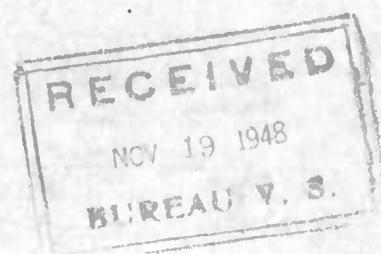
Injured at work?

## 23. SIGNATURE

Address

Rising Sun, Md. Date signed 11-17-48

Medical Examiner  
for Cecil County  
M. D. or other



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11337  
55d

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil

City or town Perry Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos. 2 days

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.

How long in hospital or institution? Same

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 608 Pearl Street

(If rural, give LOCATION)

WW-I

2.(a) If veteran, name war

## 3. (a) FULL NAME

BULETTE, Hugh E.

4. Sex male	5. Color or race white	6.(a) Single, married, widowed, or divorced Married
-------------	------------------------	---

6.(b) Name of husband or wife Mrs. Florence Bulette

7. Birth date of deceased (mo. day, yr.) January 8, 1896

8. AGE: Years 52	Months 10	Days 1	If less than one day hrs. min.
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9. Birthplace Pennsylvania  
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

12. Name James O. Bulette - deceased

13. Birthplace Harford County, Md.

14. Maiden name Clara Founds

15. Birthplace Cecil County, Md.

16. Informant Wife, Mrs. Florence Bulette

Address 608 Pearl St., Havre de Grace, Md.

17. Burial Date thereof Nov. 12, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Slate Hill Cemetery

Location Harford County, Maryland

18. Funeral director R. MADISON MITCHELL

Address HAVRE DE GRACE, MD.

19. Nov. 10 1948 Issue S. Daugherty

(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948, at 10:30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 7, 1948, to Nov. 9, 1948,

and that I last saw him alive on November 9, 1948.

Immediate cause of death

Pneumonia, lobar, right lower lobe

DURATION

48 hrs.

Due to Abscess, right temporal lobe

Due to Sarcoma, maxillary process, sclerosing type

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury --- Injured at work?

23. SIGNATURE A. E. TROLLINGER, M.D., Chief, Professional Staffs.

M. D. or other

Address VAH, Perry Point, Md. Date signed Nov. 10, 1948





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11338

## CERTIFICATE OF DEATH

Reg. Dist. No. 469 95

## 1. PLACE OF DEATH:

County... CecilCity or town... Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Clara O Coale

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white widowed

6.(b) Name of husband or wife

Samuel Coale

Decreas

years

7. Birth date of deceased (mo., day, yr.)

6-27-1869

8. AGE:

Years

Months

Days

If less than one day

79

4

8

hrs.

min.

9. Birthplace

Porter's Bridge, Cecil Co, Md.

(To..., county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER / FATHER

12. Name... Samuel A Hindman13. Birthplace Polksville, Md.

14. Maiden name

Martha Kennard

15. Birthplace

Colora, Md.

16. Informant

Hassiette Little

Address

Rising Sun, Md.

17. Burial

Burial 9 Date thereof 11-9-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Westonstrigham Cemetery

Location

Colora, Md.

18. Funeral director

Ralph M Reed

Address

Rising Sun, Md.

19. (Date rec'd by registrar)

Nov 8 1948 LMW/strighton

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County...

CecilCity or town... Rising Sun

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No... Pearl Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

November 5 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1948 to Nov 4 1948and that I last saw him alive on Nov. 4 1948

Immediate cause of death

concerning  
of Reiter

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Pelham Coale

M. D. or other

Address

Young Sward Date signed 11-6-48

1  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

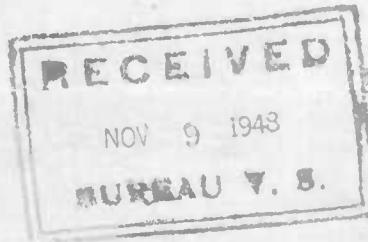
62-9-6981

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8-7-66  
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8-7-66  
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8-7-66



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11339

Reg. Dlat. No. 92

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Ebeton

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 hours

Hospital, institution, or street address where death occurred:

Alum Rock Ebeton Md.

How long in hospital or institution?

3 hours

## 3. (a) FULL NAME

Joan Marie Cornell.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

October 24 1948

## 8. AGE:

Years Months Days

If less than one day

12 . hrs. min.

## 9. Birthplace

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER

Joseph M. Cornell.

Baking See M

MOTHER

Susan Strizacko

St. Clair, Panama

## 16. Informant

## Address

Joseph M. Cornell.

North East Md.

Burial

Date thereof 11 - 8 - 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brookview Cemetery

Location Rising Sun Md.

18. Funeral director Joseph P. Grant

Address North East Md

19. Nov 8 1948

(Date rec'd by registrar) F. R. Frazer

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Cecil

City or town

North East Rural

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Nov. 5 1948 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h. alive on

Immediate cause of death

Convulsions

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

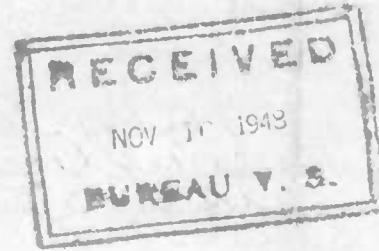
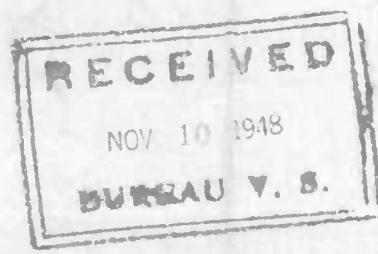
Means of injury

Injured at work?

23. SIGNATURE \_\_\_\_\_ Medical Examiner  
for Cecil County

M. D. or other

Address \_\_\_\_\_ Date signed \_\_\_\_\_



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11340

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil

City or town Elston Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 9 days

## 3. (a) FULL NAME

Sara Amelia Crouch

## 4. Sex

F

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Benjamin F. Crouch

## 6. (c) If alive, give age.....years

Nov. 25 1874

## 7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

74

1

hrs.

min.

## 9. Birthplace

Sassafras Md.

(Town, county, and state)

## 10. Usual occupation

At Home

## 11. Industry or business

John Gary

## 12. Name

No Information

## 13. Birthplace

Martha Commegey

## 14. Maiden name

Kent Co. Md.

## 15. Birthplace

Benjamin Crouch

## 16. Informant

Elston Md R.D.

## Address

Burial Date thereof 11-28-48

## (Burial, cremation, or removal, Which?)

(month) (day) (year)

## Cemetery or cemetery

Cecilton

## Location

Cecilton Md

## 18. Funeral director

H.W. Pippin &amp; Son

## Address

Elston Md.

## 19. Date rec'd by registrar

Nov. 27 1968

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ~~State~~ Md. County Cecil

City or town Elston R.D. #5

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

November 25 1948 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 16 1948 to Nov. 25 1948  
and that I last saw her alive on Nov. 24 1948

## Immediate cause of death

Acute cardiac failure

## DURATION

hours

Due to Fracture of pelvis  
Fracture left hip

Due to Fracture of left femur

Nov 16 1948

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Resident Date of 11/16/48Where did injury occur? Chestnut and 1st Ave (City of town) (County) (State)Injured at home, farm, industry, public place (where?) At homeMeans of injury Fell on steps Injured at work? No

## 23. SIGNATURE

M. D. or other H. J. Davis MDAddress Oesperher et al Date signed 11/26/68

RECEIVED  
NOV 29 1948  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correctness  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11341

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County.....

*Cecil*

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*M. Emma Davis*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female white single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

*Dec. 17 1882*

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

*Cecil Maryland*

10. Usual occupation

*Housework*

11. Industry or business

*Robert Davis*

12. Name

13. Birthplace

*Glasgow*

14. Maiden name

*Elizabeth Wooley*

15. Birthplace

*Maryland*

16. Informant

*Mr. James Davis*

Address

*Jalena Md.*

17. Burial

Date thereof.....

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

*Cecilton*

Location

*Cecilton Md.*

18. Funeral director

*Edward Eller*

Address

*Millington Md.*

19. Nov 16 1948

(Date rec'd by registrar)

19. " Mrs. Edward W. Cheyney

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

*Md.*

County.....

*Cecilton*

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

*none*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 13 1948 at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 10 1934 to Nov 13 1948*

and that I last saw her alive on Nov 12 1948

Immediate cause of death.....

*myocardial failure*Due to..... *chronic myocarditis*DURATION  
1 dayDue to..... *mitral insufficiency*

14 years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

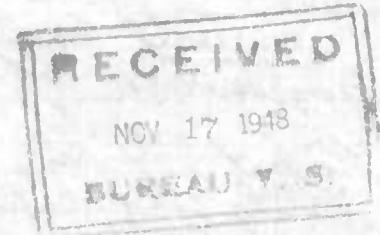
Injured at work?

23. SIGNATURE.....

*Allan R. Crouchley M. D.*

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11342

518

Reg. Dist. No. 92

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County CECIL COUNTY

City or town ELKTON, M.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 DAYS

Hospital, Institution, or street address where death occurred:

UNION HOSPITAL

How long in hospital or institution? 11 DAYS

## 3. (a) FULL NAME

WILLIAM, DEMPSEY

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

MARRIED

## 6. (b) Name of husband or wife

BERTHA

Dempsey

## 7. Birth date of deceased (mo. day, yr.)

JULY 31<sup>st</sup> 1813

6. (c) If alive, give age 70 years

## 8. AGE:

Year 75

Months 3

Days 25

If less than one day hrs. min.

## 9. Birthplace

CECIL COUNTY, MARYLAND  
(Town, county, and state)

## 10. Usual occupation

MILL WORKER

## 11. Industry or business

12. Name JOHN DEMPSEY

13. Birthplace MARYLAND

14. Maiden name SARA GRAY

15. Birthplace MARYLAND

16. Informant Mrs. Bertha Dempsey

Address ECKTON, MD

17. Burial Date thereof Nov 29 '48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Grace Lain Mem. Park

Location Wilmington, Del

18. Funeral director P. J. Jones

Address Newark, Del

19. Nov 28 '48

(Date rec'd by registrar) F. B. Frazer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ND

County

CECIL

City or town R.D.5

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1948 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1944 to Nov 26 1948

and that I last saw him alive on Nov 25 1948

Immediate cause of death

Carcinoma of Prostate  
with metastasis

DURATION

1 year

Due to

Due to

Other conditions Cardio vascular  
renal disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury

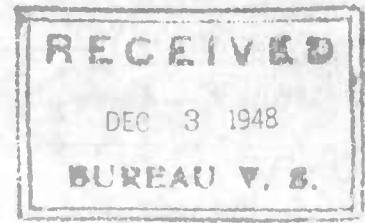
Injured at work?

23. SIGNATURE

H. Bertha Bals M.D.

M. D. or other

Address ECKTON, MD Date signed 11/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11343

93d

## CERTIFICATE OF DEATH

Reg. Date. No. 92

## 1. PLACE OF DEATH

County

City or town

*Cecil  
Hollingsworth Manor Elton*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

*5 years.*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M. Blute Widower*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

*Oct. 14 1877.*

6. (c) If alive, give age: years

8. AGE:

Years	Months	Days	If less than one day
71	26	hrs.	min.

9. Birthplace

(Town, county and state)

10. Usual occupation

*Lein Engineer*

11. Industry or business

*Daniel Downey*

12. Name

*Newcastle England*

13. Birthplace

*Mary Stratford*

14. Mother's name

*Newcastle England.*

15. Birthplace

*Daniel R. Downey*

16. Informant

*804 Hollingsworth Manor Elton*

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

*Saint Paul*

Location

*Chestertown Md*

18. Funeral director

*Edgar L. Lane*

Address

*Church Hill Md*

19. Date rec'd by registrar

*Nov 10 1948*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Cecil*City or town *Hollingsworth Manor.* (If outside city or town limits, write RURAL and give nearest town)Street No. *204* (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Nov. 9 1948 at 8 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

Immediate cause of death

*lethargic  
dry cardiac*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Alfred D. Downey MD* Medical Examiner for Cecil County, M. D. or otherAddress *Chestertown Md* Date signed *11-9-48*

M

I



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11344  
93d

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

## 1. PLACE OF DEATH:

County..... Cecil

City or town..... Perry Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 7 months 16 days

Hospital, Institution, or street address where death occurred:

VA Hospital, Perry Point, Md.

How long in hospital or institution?..... Same

## 3. (a) FULL NAME

DRAKE, Frank L.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

Negro

Single

6.(b) Name of husband or wife..... --

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Dec. 4, 1896

8. AGE: Years

Months

Days

If less than one day

51

11

6

hrs.

min.

9. Birthplace..... Virginia

(Town, county, and state)

10. Usual occupation..... Canner

11. Industry or business

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Hospital records

Address..... VA Hospital, Perry Point, Md.

17. Burial..... Removal..... Date thereof..... Nov. 16, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Baltimore National Cemetery

Location..... Baltimore, Maryland

18. Funeral director..... Pennington & Son  
Address..... Havre de Grace, Md.19. Date rec'd by registrar..... Nov. 16, 1948  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia

County.....

City or town..... Richmond

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 429 Fulton Street

(If rural, give LOCATION)

WW-I

2.(a) If veteran, name war.

## 3. (b) Social Security Number

215-16-5060

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... November 10, 1948, at 7:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 24, 1948, to Nov. 10, 1948,

and that I last saw him alive on November 10, 1948.

Immediate cause of death.....

Arteriosclerotic heart disease

DURATION

Unknown

Due to..... Arteriosclerosis, coronary  
and cerebral embolus

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... --

Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... --

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

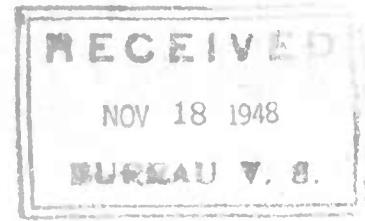
Injured at home, farm, industry, public place (where?)..... --

Means of injury..... --

Injured at work?..... --

23. SIGNATURE..... A. E. TROLLINGER

M. D. or other  
A. E. TROLLINGER, M.D., Chief, Professional Svcs.  
Address..... VAH, Perry Point, Md. Date signed..... Nov. 16, 1948



PERSONAL INF: (items 12-15 incl): statement of sister, MARY DUNPHY of 18 E. 22 st. Balto Md.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

LL 11-24-

55b  
11345

48

Reg. Dist. No. 96

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....CecilCity or town.....Perry Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....11 mos. 17 days

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.How long in hospital or Institution?.....Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....BaltimoreCity or town.....Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....18 E. 22nd Street

(If rural, give LOCATION)

W-11

2.(a) If veteran, name war

## 3. (a) FULL NAME

DUNPHY, Lester J.4. Sex.....male 5. Color or race.....white 6.(a) Single, married, widowed, or divorced.....Married6.(b) Name of husband or wife.....Marie Dunphy

6.(c) If alive, give age.....years

7. Birth date of deceased (mo. day. yr.).....Sept. 20, 19208. AGE: Years.....28 Months.....1 Days.....29 If less than one day.....hrs.....min.9. Birthplace.....Baltimore, Md.  
(Town, county, and state)10. Usual occupation.....Laborer

11. Industry or business

12. Name.....Unknown Lester Gregory Dunphy  
13. Birthplace.....Unknown Baltimore Md.14. Maiden name.....Unknown ELIA HAGEN  
15. Birthplace.....Unknown Baltimore Md.16. Informant.....Hospital Records  
Address.....VA Hospital, Perry Point, Md.17. Removal.....Baltimore National Cemetery  
(Burial, cremation, or removal. Which?) Date thereof.....Nov. 20, 1948  
(month) (day) (year)Cemetery or crematory.....Baltimore National CemeteryLocation.....Baltimore, Maryland18. Funeral director.....PENNINGTON & SON  
Address.....Laurel de Grace, Maryland19. Date.....Dec. 2d 19.....48 Name.....James E. Dougherty  
(Date rec'd by registrar) Registrar.....J. E. Dougherty

## 3. (b) Social Security Number

212-12-9702

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....November 19, 1948 at 12:29 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 2, 1947 to Nov. 19, 1948and that I last saw h. in alive on November 19, 1948Immediate cause of death.....Sarcoma, osteogenic, right humerus with metastases to clavicle, xxx scapula, lungs and pleura Approx. 20 months

DURATION

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....None Date of.....Where did injury occur?.....None (City or town) (County) (State)Injured at home, farm, industry, public place (where?).....NoneMeans of injury.....None Injured at work?.....None23. SIGNATURE.....J. E. Trollingher M. D. or other

A. E. TROLLINGER, M.D., Chief, Professional Svcs.

Address.....VAH, Perry Point, Md. Date signed.....11-19-48

RECEIVED

NOV 24 1948

BUREAU V. S.

## STATE OF MARYLAND—CERTIFICATE OF DEATH 11346

## MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1. PLACE OF DEATH

County Cecil  
Village or City Warwick

Registration Dist. No. 90

No. \_\_\_\_\_ St., \_\_\_\_\_ Ward  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

2. FULL NAME Baby Ellingsworth, Judith Anne If U. S. Veteran, specify WAR(a) Residence: No. Warwick Md.

St., \_\_\_\_\_ Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>
----------------------	-------------------------------	--

Se. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6. DATE OF BIRTH (month, day, end year) Nov. 11th 1948

7. AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
			1	

OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
	10. Date deceased last worked at this occupation (month and year)
	11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Warwick Md.  
(State or country)13. NAME Kirby Ellingsworth14. BIRTHPLACE (city or town) Delaware  
(State or country)15. MAIDEN NAME June Manlove16. BIRTHPLACE (city or town) Md.  
(State or country)17. INFORMANT Kirby Ellingsworth  
(Address) Warwick

## 18. BURIAL, CREMATION, OR REMOVAL

Place Townsend cemetery Date 11/12/ 194819. UNDERTAKER John J. Denison  
(Address) main street20. FILED 11/12 1948 Mrs. Harriet Wesley  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Nov. 11th, 1948  
(Month) (Day) (Year)22. I HEREBY CERTIFY. That I attended deceased from 11/11/48, 1948, to 11/11/48, 1948.I last saw her alive on 11/11/48, 1948; death is said to have occurred on the date stated above, at 9 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Premature birth

## Other Contributory Causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) Charles H. Kent M. D.  
(Address) Townsend R. S. Due

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

## Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	NOV 15 1948
Peritonitis	3 days ago

Other contributory causes of importance:

Gallstones	May 1, 1923	Gastroenteritis	1 year
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**ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN**

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✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11347

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: *Cecil*

County.....

City or town..... *Elkton Union Hospital*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *69 years*Hospital, Institution, or street address where death occurred: *Union Hosp.*How long in hospital or institution? *4 days*

## 3. (a) FULL NAME

*James F. Evans*

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

*Male**white**married*

6. (b) Name of husband or wife

*Margaret Evans*

x

7. Birth date of deceased (mo., day, yr.)

*Jan 19 1873*

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*75 10*

hrs. ....

min.

9. Birthplace.....

*Elkton Md*

(Town, county, and state)

10. Usual occupation.....

*Lawyer*

11. Industry or business

12. Name.....

*William Steele Evans*

13. Birthplace.....

*Rising Sun Md*

14. Maiden name.....

*Jennie Frazer*

15. Birthplace.....

*Elkton Md*

16. Informant.....

*Stanby Evans*

Address.....

*Elkton Md*

17. Burial.....

Date thereof *Nov 21 1848*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

*Elkton cemetery*

Location.....

*Elkton Md*

18. Funeral director.....

*H W Pigg*

Address.....

*Elkton Md*

19. Nov 20 1948

(Date rec'd by registrar)

*F H Frazer*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland*

County.....

*Cecil*

City or town.....

*Elkton*

(If outside city or town limits, write RURAL and give nearest town)

Street No..... *East Main St*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Nov. 19 1848*at *3:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Nov. 12 - 1948* to *Nov. 19 1948*and that I last saw h. m. alive on *Nov. 19 1948* at *19 45*

Immediate cause of death.....

*Cerebral Embolism*Due to *Hypertension & myocarditis*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

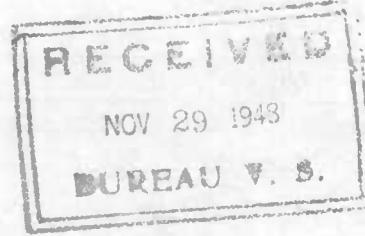
*Justus Hartmann Jr.*

Mr. or other

Address.....

Date signed

*Nov 20 1948*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11348

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County.....

*West Cecil*

City or town.....

*Cecilton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

*all day*

Hospital, Institution, or street, address where death occurred:

*Cecilton*

How long in hospital or institution?.....

## 3. (a) FULL NAME

*J. A. Roberts Ferguson*

4. Sex

*Male*

5. Color or race

*white*

6. (a) Single, married, widowed, or divorced

*Married*

6. (b) Name of husband or wife.....

*Emma B Ferguson*

6. (c) If alive, give age..... years

*81*

7. Birth date of deceased (mo., day, yr.)

*March 22 1857*

8. AGE:

Years

Months

Days

It less than one day

*91**8**5*

9. Birthplace.....

*West Cecil Co. Cecil Co. Md.*

(Town, county, and state)

10. Usual occupation.....

*Farm**Farming*

11. Industry or business

*Farm**Farming*

12. Name.....

*John Edward Ferguson**John Edward Ferguson*

13. Birthplace

*Cecilton Co. Maryland**Cecilton Co. Maryland*

14. Maiden name.....

*Margaret Emma James**Margaret Emma James*

15. Birthplace

*Cecilton Co. Maryland**Cecilton Co. Maryland*

16. Informant.....

*Mr. Emma B Ferguson (son)**Mr. Emma B Ferguson (son)*

Address

*Cecilton, Cecil Co. Maryland**Cecilton, Cecil Co. Maryland*

17. Burial

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

*Cecilton**Cecilton*

Location

*Cecilton, Cecil Co. Maryland**Cecilton, Cecil Co. Maryland*

18. Funeral director.....

*Wm. V. Williamson**Wm. V. Williamson*

Address

*Chesterfield, Maryland**Chesterfield, Maryland*

19. Date rec'd by registrar.....

*Nov 30 1948**Miss Harriet W. Clayman*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

 *Maryland*

County.....

*Cecil*

City or town.....

*Cecilton*

(If outside city or towg limits, write RURAL and give nearest town)

Street No.....

*Cecilton*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 30 1948 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 33 Nov 27 1948

and that I last saw him alive on Nov 26 1948

Immediate cause of death.....

*Paralysis of Throat  
muscle*

Due to.....

*General weakness*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Misses of injury..... Injured at work?

23. SIGNATURE..... H. J. Don, M.D. M. D. or other

Address..... Chesterfield, Maryland Date signed..... Nov 30 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11349  
94

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County..... Cecil

City or town..... North East (Rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 8 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Peter David Gysin

4. Sex..... Male | 5. Color or race..... White | 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Maysie Alice Gysin

7. Birth date of deceased (mo., day, yr.)..... October 10 1900

8. AGE: Years..... 48 Months..... 1 Days..... 10 If less than one day..... hrs. ..... min. ....

9. Birthplace..... Switzerland  
(Town, county, and state)

10. Usual occupation..... Salesman

11. Industry or business..... Furniture

12. Name..... John Gysin

13. Birthplace..... Switzerland

14. Maiden name..... Bertha David

15. Birthplace..... Switzerland

16. Informant..... Mrs. Peter D. Gysin

Address..... North East, Md. R.D.

17. Removal..... Date thereof NOV. 22 1948  
(Burial, cremation, or removal. Which?)

Cemetery or mortuary..... Oakhill

Location..... Battle Creek, Michigan

18. Funeral director..... Joseph P. Grant

Address..... North East, Maryland

19. Nov. 22, 1948  
(Date rec'd by registrar)Sarah E. Rottermel  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... North East (Rural)  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war..... NO

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 20, 1948 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 20, 1948, to Nov. 20, 1948,  
and that I last saw him alive on Nov. 20, 1948,

Immediate cause of death.....

Coronary &amp; thrombosis 5 hours

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

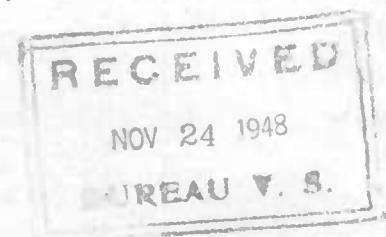
Means of injury .....

Injured at work? .....

23. SIGNATURE.....

M. D. or other .....

Address..... North East, Maryland Date signed Nov 21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11350  
131-b

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Nov. 9, 1870

6.(c) If alive, give age.....

years

8. AGE:

Years

Months

Days

If less than one day

78

—

3

hrs.

min.

9. Birthplace.....

Princess Anne, Md.

(Town, county, and state)

10. Usual occupation.....

at Home

11. Industry or business

MOTHER

FATHER

12. Name.....

William Lamar

13. Birthplace.....

Princess Anne, Md.

14. Maiden name.....

no fig

15. Birthplace.....

no fig

16. Informant.....

Mr. Henry Herwin

Address.....

Elkton, Md.

17. Burial.....

Date thereof.....

Nov. 15

(month) (day) (year)

Cemetery or crematory.....

Elkton

Location.....

Elkton, Md.

18. Funeral director.....

Hartmann

Address.....

Elkton, Md.

19. Date rec'd by registrar.....

Nov. 15 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Elkton

City or town.....

Elkton

Street No.....

Main St

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

November 12

1948

a.m.

5 p.m.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3, 1948, to November 12, 1948, and that I last saw her alive on November 12, 1948.

Immediate cause of death.....

Corticosteroids

Causing

Cortisol

Cortisone

Cortisol

STATION TO THE HIGHEST STATE ATTORNEY  
RECEIVED NOV 17 1948  
RECEIVED BY STANFORD



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195

1135196

Reg. Diat. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Cecil County

City or town Perry Point, Maryland

(If outside city or town limits, write RURAL and give nearest town)

2 Months 11 Days

How long in above place of death?

Hospital, institution, or street address where death occurred:

VAH., Perry Point, Maryland

2 Months 11 Days

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia

County

City or town Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No. 419 Wilkes Street

(If rural, give LOCATION)

WW-II

2.(a) If veteran, name war

## 3. (a) FULL NAME

JEWELL, Millard E.,

## 4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

## 6.(b) Name of husband or wife

Virginia R. Jewell

6.(c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

August 23, 1919

## 8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to... 19...

19...

and that I last saw him alive on

1. Fracture of the Parietal

DURATION

extending into the frontal. 2-Cerebral

Hemorrhage. 3 Fracture of 2nd rib,

left side. 4. Fracture of Rt.

Humerus, multiple. 5. Multiple

lacerations of the face and head.

Due to

6. Fracture of the Liver.

7. Laceration of the mesentery.

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

Accident

Date of

Where did injury occur? VAH, Perry Point, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Hospital Road

Means of injury

Medical Examiner

Reed Odson, M.D., Cecil County

Address

Rising Sun, Maryland

Date signed

VS A15 9-45-15M

23. SIGNATURE. R.C. DODSON, M.D., Coroner, Cecil Co.

M.D. or other M.D.

11-13-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11352  
468

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... CECIL

City or town..... PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 10 das.

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.

How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Cecil

City or town..... Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 139 E. High Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

## 3. (a) FULL NAME

ERNEST KEMPA

## 4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife..... Esther Kempa

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo. day, yr.) November 27, 1888

8. AGE: Years 59 Months 11 Days 5 If less than one day hrs. min.

9. Birthplace..... Elkton, Maryland  
(Town, county, and state)

10. Usual occupation..... Clerk

11. Industry or business

12. Name..... Unknown

13. Birthplace

14. Maiden name..... Unknown

15. Birthplace

16. Informant..... Hospital Records

Address VAH, Perry Point, Md.

17. Removal Date thereof 11/2/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Elkton Cemetery

Location..... Elkton, Maryland

18. Funeral director..... JOSEPH GRA. NT

Address North East, Maryland

19. Date rec'd by registrar..... Nov. 2 1948

(Date rec'd by registrar)

## 3. (b) Social Security Number

215-10-7402

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 2 1948 at 6:00A.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 22 1948 to Nov. 2 1948

and that I last saw h. im. alive on November 2 1948

Immediate cause of death..... Carcinoma of the stomach,

generalized carcinomatosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Generalized carcinomatosis,  
primary site probably in recto-sigmoid Date of op. 9-30-48

Autopsy results..... Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. -- Date of --

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l'c place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE..... A. E. TROLLINGER, M.D., Chief Prof. Serv.

M. D. or other

VAH, Perry Point, Md. Date signed 11/2/48

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

131a  
11353

## 1. PLACE OF DEATH:

County

Cecil  
Near Blue Ball, Md.

(If outside city or town limits, write RURAL and give nearest town)

City or town  
How long in above place of death? 40 yrs.  
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Margaret L. Kinlow

4. Sex

Female Colored

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Henry T. Kinlow

7. Birth date of deceased (mo., day, yr.)

June 7, 1874

6.(c) If alive, give age

years

8. AGE:

Years Months Days If less than one day  
74                hrs.      min.

9. Birthplace

Penns. (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Alfred Hammond

MOTHER FATHER

12. Name

Alfred Hammond

13. Birthplace

Maryland

MOTHER

14. Maiden name

Rachel Robertson

15. Birthplace

Maryland

16. Informant

Anne Kinlow Smith

Address

Elkton Md. RD 14

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 12 3 1948  
(month) (day) (year)

Cemetery or crematory

Trinity Cemetery, Zion, Md.

Location

Zion, Md.

18. Funeral director

Edward Bell

Address

909 Poplar St. Wil. Sch.

See

3 1948

(Date rec'd by registrar)

J. H. Frazer  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Cecil

City or town

Rural District (If outside city or town limits, write RURAL and give nearest town)

Street No.

Near Blue Ball Md. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7 1948 to November 28 1948

and that I last saw her alive on November 23 1948

Immediate cause of death

Chronic Myocarditis

DURATION

6 years

Due to

Interstitial nephritis

6 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

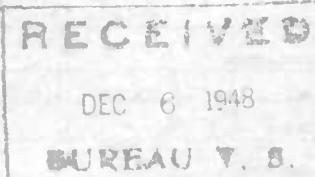
Injured at work?

23. SIGNATURE

James Johnson MD M. D. or other

Address

Elkton, Md. Date signed 11/1/48



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11354  
61  
94

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Cecil

City or town.....

North East Rural  
Lifeline

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

William H Letts

7. Birth date of deceased (mo., day, yr.)

Sept 17 1899

6. (c) If alive, give age 50 years

8. AGE:

Years 49

Month

Days

If less than one day

18 hrs. min.

9. Birthplace

North East, Cecil Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

U. S. Demond

12. Name

Md

13. Birthplace

Ella Liley

14. Maiden name

Wm H Letts

15. Birthplace

North East, Md

16. Informant

Burial

Date thereof Nov 1 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory North East Methodist

Location North East Md

18. Funeral director Joseph R. Giam

Address North East Md

19. Nov 6 1948

(Date rec'd by registrar)

Sarah E. Pothamel

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md County.....

City or town.....

North East Rural

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 10 1948 to November 4 1948

and that I last saw her alive on November 3 1948

Immediate cause of death

Cardiac insufficiency

Due to nephritis, hypertension

Due to Diabetes

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

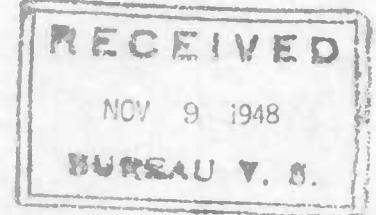
Means of injury

Injured at work?

23. SIGNATURE

James L. Johnson M.D. or other

Address Elizabeton, Md Date signed Oct 16 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11355

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

M  
Margin reserved for binding

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County..... *Cecil*

City or town..... *North East, Rural*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *Lifetime*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Cecil*

City or town..... *North East, Rural*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

*William M Logan*

4. Sex *m* 5. Color or race *w* 6.(a) Single, married, widowed, or divorced *Single*

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) ..... 6. (c) If alive, give age ..... years  
*Sept 1870*

8. AGE: Years *78* Months ..... Days ..... If less than one day ..... hrs. ..... min.

9. Birthplace..... *North East, Rural, Md*  
(Town, county, and state)

10. Usual occupation..... *Farmer*

11. Industry or business

MOTHER FATHER 12. Name..... *Benjamin F. Logan*

13. Birthplace..... *Maryland*

14. Maiden name..... *Harriet Burns*

15. Birthplace..... *Maryland*

16. Informant..... *John G Logan*

Address..... *North East, Md*

17. Burial..... Date thereof..... Nov 30, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Bayview Methodist*

Location..... *Bayview, Maryland*

18. Funeral director..... *Joseph R. Lewis*

Address..... *North East, Md*

19. Now 30 1948 Sarah E. Rothermel  
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

*none*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *27 Nov 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 1948* to *Nov 1948*, and that I last saw h. i. *alive* on *27 Nov 1948*.

Immediate cause of death. *① Uremia* DURATION

*② S. F. Heart Failure*

Due to *① Benign Prostatic Hypertrophy*

*② Stage III*

Due to *A.S.C.V.D.*

Other conditions *Ch. Cystitis & Pyuria*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*W.H. Sadrowsky MD*  
M. D. or other  
Address..... *Perryville, Md*  
Date signed..... *27 Nov 1948*

RECEIVED

DEC 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11356  
95

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County.....*Cecil*City or town.....*Rising Sun, Rural.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Robert Thomas MacCaulley*

4. Sex

*Male*

5. Color or race

*White*

6.(a) Single, married, widowed, or divorced

*Single*

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

*Aug. 12. 1946*

8. AGE:

Years  
*2*Months  
*2*Days  
*23*If less than one day  
hrs. .... min. ....

9. Birthplace.....

(Town, county, and state)  
*Elton, Md.*

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....*Fances MacCaulley*

13. Birthplace

*Bowlandville, Md.*

MOTHER

14. Maiden name.....*Eva McGlothlin*

15. Birthplace

*Grundy, Va.*

16. Informant.....

*Fances MacCaulley.*

Address

*Nottingham, Pa. R.R.D.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....*Nov. 10. 1948*  
(month) (day) (year)

Cemetery or crematory.....

*West Nottingham*

Location.....

*Near Colona.*

18. Funeral director.....

*J. E. Jason*

Address

*Rising Sun, Md.*

19. Date issued by registrar

*Nov. 8-1948*

(Date issued by registrar)

*1-8-48*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md.*

County.....

*Cecil*City or town.....*Rising Sun*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*December 6 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*11-3 1948* to *11-6 1948*and that I last saw h. *in* alive on *11-6 - 1948*

Immediate cause of death

*Convulsions*

Due to.....

*Infectious Disease*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

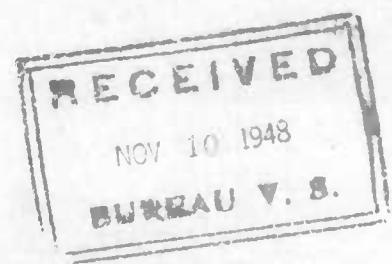
Means of injury.....

Injured at work? .....

23. SIGNATURE.....

D. or other \_\_\_\_\_ Date Signed *11-6-48*

Address.....



Evidence for change of MARYLAND STATE DEPARTMENT OF HEALTH  
 age and birth date shown on: 2411 N. Charles St., Baltimore  
 FILE NO. G 110 DEC - 3 1948 CERTIFICATE OF DEATH

11357

94

Reg. Distr. No.

83b

1. PLACE OF DEATH:

County

CECIL

City or town

NORTH EAST

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

NORTH EAST - R.D. 1

How long in hospital or institution?

3. (a) FULL NAME

JOSEPH B. MCKINNEY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.

WHITE

MARRIED

6.(b) Name of husband or wife

BERTHA H.

7. Birth date of deceased (mo., day, yr.)

JAN. 18 1878

71

years

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>69</u>		

hrs.

min.

9. Birthplace

MD.

(Town, county, and state)

10. Usual occupation

GUARD

11. Industry or business

GOVT.

FATHER

12. Name

AMOS MCKINNEY

13. Birthplace

MD.

MOTHER

14. Maiden name

GROVES

15. Birthplace

MD.

16. Informant

BERTHA H. MCKINNEY

Address

NORTH EAST R.D. 1

17. BURIAL

Date thereof NOV 23 1948  
 (Burial, cremation, or removal. Which?)  
 (month) (day) (year)

Cemetery or crematory

BETHEL CEM. CHESAPEAKE

Location

Chesapeake City - MD.

18. Funeral director

Joseph R. Grant

Address

North East, Maryland

19. Date rec'd by registrar

NOV 20 1948

Sarah E. Rutherford

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD.

County CECIL

City or town NORTH EAST

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

20 Nov 1948 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1948 to 20 Nov 1948

and that I last saw h.i.m. alive on

19 Nov 1948

Immediate cause of death

Bronchopneumonia

DURATION

7 days

Due to Cerebral Thrombosis - left

3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

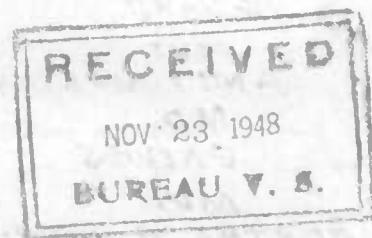
Injured at work?

23. SIGNATURE

Klaus H Huebner M.D.

M. D. or other

Address North East, Md Date signed 20 Nov 1948



PLEASE WRITE PLAINLY,  
WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11358  
1952

## CERTIFICATE OF DEATH

Reg. Distr. No. 96

## 1. PLACE OF DEATH:

County..... **Cecil**City or town..... **Perry Point**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **3 1/2 hrs.**

Hospital, institution, or street address where death occurred:

..... **VA Hospital, Perry Point, Maryland**How long in hospital or institution?..... **Same**

## 3. (a) FULL NAME

**MOLLOHAN, Frank M.**

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

Divorced

6. (b) Name of husband or wife.....

**Unknown**

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

**October 10, 1908**

8. AGE: Years

Months

Days

If less than one day

40

0

25

hrs.

min.

9. Birthplace.....

**West Virginia**

(Town, county, and state)

10. Usual occupation.....

**Machinist**

11. Industry or business

MOTHER FATHER

12. Name..... **Gary E. Mollohan**

13. Birthplace

**Clay County, W.Va.**

14. Maiden name.....

**Lizzie Mollohan**

15. Birthplace

**Braxton Co., W.Va.**

16. Informant.....

**Brother, John Mollohan**

Address

**2329 Ruth Ave., Edgemere, Md.**

17. Removal.....

Date thereof..... **11-5-48**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

**Richwood Cemetery**

Location.....

**Richwood, West Va.**

18. Funeral director.....

**PENNINGTON & SON**

Address

**Havre de Grace, Maryland**

19. Year.....

**5**

(Date rec'd by registrar)

**1948**Signature..... *John E. Draper*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **West Virginia** County..... **Nicholas**City or town..... **Richwood**

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name w/

**WW II**

## 3. (b) Social Security Number

**Unknown**

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **November 5,**1948, at **12:35 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h..... alive on.....

19

Immediate cause of death.....

**Poisoning, acute, liquid, probably an alkali**

DURATION

**Unknown**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... **As above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... **Unknown** Date of.....Where did injury occur?..... **Unknown**

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **Baltimore County**

Means of injury.....

Injured at work?

23. SIGNATURE

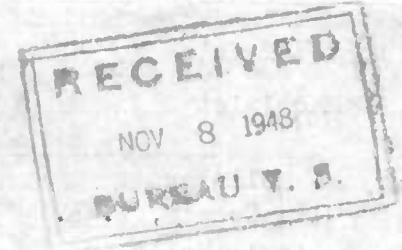
**R. C. DODSON, M.D.**Address..... **Rising Sun, Maryland**

Medical Examiner

for Cecil County

M. D. or other

11-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1135

## CERTIFICATE OF DEATH

Reg. Dlat. No. 96

## 1. PLACE OF DEATH:

County..... Cecil

City or town..... Perry Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 17 days

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.

How long in hospital or institution?..... Unknown

## 3. (a) FULL NAME

MYERS, Watson M.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife..... Mrs. Leda Williams Myers

7. Birth date of deceased (mo. day. yr.)..... November 19, 1871

8. AGE: Years	Months	Days	If less than one day
76	11	19	hra. min.

9. Birthplace..... Virginia  
(Town, county, and state)

10. Usual occupation..... Locomotive Manufacturer

## 11. Industry or business

12. Name	Williams Myers - deceased
13. Birthplace	Isle of Wight, County, Va.

14. Maiden name	Pattie White - deceased
15. Birthplace	Isle of Wight County, Va.

16. Informant	Hospital Records
Address	VAH, Perry Point, Md.

17. Removal	Date thereof..... Nov. 8, 1948
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory..... Hollywood Cemetery

Location..... Richmond, Virginia

18. Funeral director	PENNINGTON & SON
Address	Havre de Grace, Maryland

19. Date rec'd by registrar	Dec. 5, 1948
	James E. Dugay

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia County.....

City or town..... Richmond  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 314 Richmond Hotel

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I (Retired)

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

AM

20. DATE OF DEATH..... November 8, 1948, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21, 1948, to November 8, 1948,

and that I last saw him alive on November 8, 1948.

Immediate cause of death.....

Coronary sclerosis

DURATION

Unknown

Due to..... Arteriosclerosis, generalized

Unknown

Due to.....

Other conditions..... Bronchopneumonia, bilateral

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

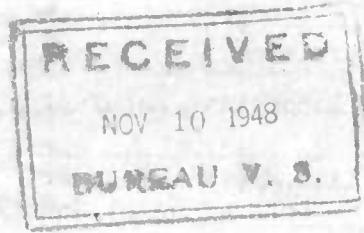
Means of injury.....

Injured at work?

23. SIGNATURE.....

A.E. TROLLINGER, M.D., Chief, Professional Svcs.

Address..... VAH, Perry Point, Md. Date signed..... 11-8-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11360

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH: Cecil.

County.....

City or town..... Chesapeake City.

(If outside city or town limits, write MURAL and give nearest town)

How long in above place of death? Type.

Hospital, institution, or street address where death occurred:

Chesapeake City, Md.

How long in hospital or Institution?

## 3. (a) FULL NAME

John Theodore Nowland

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W. Widowed6. (b) Name of husband or wife..... Matthew T. Nowland7. Birth date of deceased (mo., day, yr.) March 10 / 1870

6. (c) If alive, give age..... years

8. AGE: Years 78 Months 8 Days 3 If less than one day hrs. min.9. Birthplace..... Chesapeake City,  
(Town, county, and state)10. Usual occupation..... Retired.

## 11. Industry or business

12. Name..... John Nowland13. Birthplace..... Chesapeake City,14. Maiden name..... W. J. J.

15. Birthplace.....

16. Informant..... Edward T. NowlandAddress..... Chesapeake City, Md.17. Burial..... Burial Date thereof Nov. 16/48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Bethel.Location..... New Chesapeake City, Md.18. Funeral director..... H. W. ChapmanAddress..... Elkton, Md.19. (Date rec'd by registrar) Nov 16/48 Reg. No. 13818

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County.....

Cecil.

City or town..... Chesapeake City

(If outside city or town limits, write RUR/RY and give nearest town)

Street No..... Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 13 1948 at 2<sup>00</sup>

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 48 to Nov 13 1948and that I last saw him alive on Nov 13 1948

Immediate cause of death.....

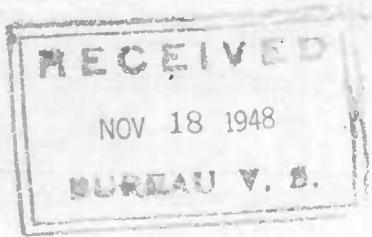
Pulmonary tuberculosis

DURATION

2 years

Diseases.....

Due to.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11361

## CERTIFICATE OF DEATH

Reg. Dist. No.

92

## 1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

El Dorado  
Elkton Rural  
2 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Reina E Painter

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male | Blute | Married  
Henry Painter

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

8. Birthplace

Roanoke Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Howard Green

MOTHER

FATHER

12. Name

Howard Green

13. Birthplace

Va.

14. Maiden name

Virginia Reed

15. Birthplace

Va.

16. Informant

Henry Painter

Elkton Md.

Address

Burial

Cemetery or crematory

Location

Funeral director

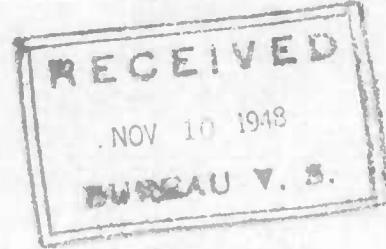
Address

Date thereof

(month)

(day)

(year)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11362

## CERTIFICATE OF DEATH

Reg. Dist. No. 94a

95

## 1. PLACE OF DEATH:

County

Cecil

City or town

Colora Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Grace V. Ramsey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

Married

6. (b) Name of husband or wife

Harry Ramsey

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.)

Sept. 20. 1879

8. AGE:

Years  
69Months  
1Days  
29At less than one day  
hrs. min.

9. Birthplace

Colora Cecil Co. md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Littleton Graves

13. Birthplace

Md.

14. Maiden name

Annie Lury

15. Birthplace

Penns.

16. Informant

Harry Ramsey

Address

Colora. md. R. R. 1.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof nov. 22. 1948

(month) (day) (year)

Cemetery or crematory

West Darlington

Location

Colora

J. E. Tyson

18. Funeral director

Price &amp; Son Ltd.

Address

Permit issued 11-20-48

19. (Date needed by registrar)

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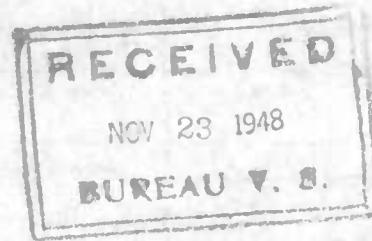
19-

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6445  
69  
8461



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11363  
gr

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

*Cecil  
Elkton Rural  
Morning at place.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *morning at place.*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

*William Howard Rothwell* | 3. (b) Social Security Number *218-09-7946*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

<i>M.</i>	<i>White</i>	<i>Single</i>
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## 6.(b) Name of husband or wife.....

## 7. Birth date of deceased (mo., day, yr.)

*July 4 1889* | 6.(c) If alive, give age..... years

## 8. AGE:

Years	Months	Days	If less than one day
<i>59</i>	<i>4</i>	<i>4</i>	hrs. min.

## 9. Birthplace.....

(Town, county, and state)

## 10. Usual occupation.....

## 11. Industry or business.....

## 12. Name.....

## 13. Birthplace.....

*William H. Rothwell*  
*Elkton Md.*

## 14. Maiden name.....

*Clarissa Dickerson*  
*Elkton Md.*

## 15. Birthplace.....

*Elkton Md.*  
*Mrs Horace Rothwell*

## 16. Informant.....

*Elkton Md.*  
*Burial*

## Address.....

*Elkton Md.*  
*Burial*

Date thereof. *Nov 11/48* (month) (day) (year)

## Cemetery or crematory.....

*Elkton*  
*Elkton Md.*

## Location.....

*Elkton*  
*Elkton Md.*

## 18. Funeral director.....

*Hulipkin*  
*Elkton Md.*

## Address.....

*Elkton Md.*  
*Nov 11 1948*

## (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. *Md.* County. *Cecil*City or town. *Elkton Rural.* (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

## 2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

2d. DATE OF DEATH. *November 8 1948 at 2 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

*Acute  
cardiac  
disease*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

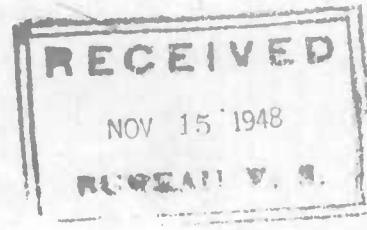
2d. SIGNATURE

*R. E. Dodsden M.D.* Medical Examiner  
for Cecil County

M. D. or other

*Rising Sun Md.* Date signed *11-9-48*

Address.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11364

## CERTIFICATE OF DEATH

Reg. Dist. No. 93d

92

## 1. PLACE OF DEATH

County.....*Elkton*City or town.....*Elkton* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*Moor Hospital - Elkton, Md.*

How long in hospital or institution?

*7 days*

## 3. (a) FULL NAME

*Laura Seward*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Female white widowed*

6.(b) Name of husband or wife

*James Moore*

7. Birth date of deceased (mo., day, yr.)

*Nov 20**Unknown*

6.(c) If alive, give age.....years

*1862*

8. AGE:

Years	Months	Days	If less than one day
<i>56</i>	<i>8</i>	<i>9</i>	<i>hrs. min.</i>

9. Birthplace.....

*Caroline County - Md.*

(Town, county, and state)

10. Usual occupation.....

*at Home*

11. Industry or business

MOTHER FATHER

12. Name.....*James Seward*

Buyers

Centreville - Md

13. Birthplace.....

*Esther McGinnies*

14. Maiden name.....

*Maryland*

15. Birthplace.....

*The deceased*

16. Informant.....

Address.....

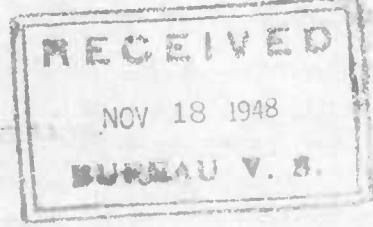
Burial

(Burial, cremation, or removal. Which?)

Date thereof.....*Nov. 17/48*

(month) (day) (year)

Cemetery or crematory.....*Townsend*Location.....*Townsend, Del*18. Funeral director.....*Hurtzippin*Address.....*Elkton, Md.*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11365  
92

## CERTIFICATE OF DEATH

97  
Reg. Dist. No.

1. PLACE OF DEATH: *Cecil*  
 County: *Elkton Md*  
 City or town: *(If outside city or town limits, write RURAL and give nearest town)*  
 How long in above place of death? *2 days*  
 Hospital, Institution, or street address where death occurred: *Elkton Hospital*  
 How long in hospital or institution? *2 days*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State: *Maryland* County: *Cecil*  
 City or town: *Elkton*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

3. (a) FULL NAME *William Walters*
 4. Sex: *male* 5. Color or race: *white* 6. (a) Single, married, widowed, or divorced: *widowed*
8. (b) Name of husband or wife: *Margaret Walters*7. Birth date of deceased (mo., day, yr.): *Aug 20 1862*

8. (c) If alive, give age: ..... years

8. AGE: Years: *86* Months: *3* Days: *2* If less than one day: ..... hrs: ..... min: .....9. Birthplace: *Chesapeake City Md*  
(Town, county, and state)10. Usual occupation: *Horseback Farming*

11. Industry or business

12. Name: *James Walters*13. Birthplace: *No information*14. Maiden name: *Margie Taylor*15. Birthplace: *No information*16. Informant: *William Walters Jr*Address: *Elkton Md R D*17. Burial: *Burial* Date thereof: *Nov 26 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory: *Cherry Hill*Location: *Cherry Hill Md*18. Funeral director: *J. C. Pippin*Address: *Elkton Md*19. Date rec'd by registrar: *Nov 24 1948* F. B. Frazer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *23 November 1948* at *8:15 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1 November 1948* to *23 November 1948* and that I last saw him alive on *23 November 1948*.

Immediate cause of death:

*Cardiac Failure*Due to: *Hypertension*Due to: *Atherosclerosis*Other conditions: *Sensibility*

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

## Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: *George J. Knecht Jr.*

M. D. or other

Address: *Elkton, Md* Date signed *11/23/48*

